Exhibit 55

TRIGON.

January 5, 2000

Ms. Karen Ford Manza
Regional Director, Managed Care
US Oncology
16825 Northchase Drive
Suite 1300
Houston, TX 77060

Dear Ms. Manza:

It was a pleasure speaking with you regarding the new Trigon Services, Inc. Agreements. I also want to thank you for forwarding your suggested changes to the agreement language. As we discussed, the Agreements have undergone significant revisions that are beneficial to your practice. However, you still have a number of concerns regarding the contract language. At this time, I would like to address your concerns in an attempt to further clarify Trigon Services, Inc.'s position on certain issues.

Exhibit H - Bundling

Further clarification necessary.

History Edits - Oncology

Further clarification necessary.

Non-Covered Oncology Services

Further clarification necessary.

Medical Necessity

As defined in the Agreements, Medical Necessity determinations are based upon the following criteria: consistent with the symptom or diagnosis and treatment of the Covered Person's condition; in keeping with standards of generally accepted medical practice; not mainly for the convenience of the patient, the patient's family, or the provider; and the most suitable supply or level of service that can be safely provided. Economic factors are not a component of Medical Necessity determinations. Determination of Medical Necessity is based upon sound clinical evidence and outcomes information. Trigon uses national medical necessity standards for these determinations.

If you disagree with a Medical Necessity determination made by Trigon and feel that it is based purely on economic factors, you should appeal the insurance claims in accordance with Virginia Code Section 32.1-137.7 *et. seq*

Experimental/Investigational

See Medical Necessity section.

A-VA 03010065
Highly Confidential

PAR/PPO Modifiers

Further clarification necessary.

Drug Pricing According to Exhibit H

Trigon recognizes that your acquisition cost for drugs is highly variable when expressed as a percent of the AWP. Ninety percent of AWP should provide you with substantial margins for some drugs and nearly zero margins for others. As you know, acquisition cost as a percent of AWP is much lower for the older and more established generics and multi-source brands. These relatively low-cost drugs provide substantial margins and are prominent in the established combination regimens for common malignancies. Therefore, on balance, providing drugs to Trigon insureds at ninety percent of AWP provides you with a positive margin, even when inventory costs are considered. At the time of future fee schedule updates, Trigon might introduce new or different allowances for drugs. It is possible that new allowances might not be based upon a constant percent of AWP. However, any fee schedule changes may be many months in the future.

Medical Documentation

Further clarification necessary.

CPT Coding and Medicare Processing Guidelines

Trigon updates its fee schedules yearly, according to Medicare's Relative Value Units, competitor payments and changes in medical technology that affect specific allowances.

General Contractual Issues

1. Although the Fair Business Practices Act only applies to insured business, you will see some changes in processes and procedures across all lines of business as a result of the changes we are making relative to the new law. For example, we will provide voluntary pre-authorization with eligibility determinations across all lines of business, and we will provide information about policies and payments consistently across all lines of business. And we will, of course, continue to strive to pay all claims promptly and accurately. However, we have only changed the procedures for requesting additional information and tracking and paying claims for our insured lines of business, as required by the law. All Covered Services provided to fully insured and self-insured Covered Persons of Affiliates listed in Exhibit A of the Agreement will be reimbursed in accordance with the applicable Schedule of Allowances in Exhibit H. Trigon's adjudication logic is consistent with industry standards and is similar to logic applied by most payors. Often, Trigon's adjudication logic is consistent with Medicare and AMA CPT methodology, but at times Trigon's logic may conflict with these guidelines. Upon request, Trigon will address any specific questions regarding rebundling, downcoding, or reduction of claims containing certain combinations of codes.
2. While the Fair Business Practices Act requires that physicians have fifteen (15) business days from receipt of an amendment to consider and provide written objection to any contract amendment, Trigon provides twenty (20) business days from postmark date to review any amendment and notify us of any objection. Amendments will become effective ninety (90)

calendar days after the review period. Likewise, any termination that results from your failure to accept an amendment will not take place until ninety (90) calendar days after the twenty (20) business day period. This timing helps ensure continuity of care and a smooth transition for our members and your patients.

3. The new Trigon Services, Inc. agreements do not contain the "most favored nations" clause. While we remain committed to ensuring the best reimbursement available for our members, we will achieve this, as we always have, by considering Medicare's Relative Value Units, competitor payments and changes in medical technology that affect specific allowances.
4. Trigon has always reserved the right to share information with its customers, network providers, and Covered Persons. In fact, some of the language in this section is taken verbatim from the previous agreement. In an improvement from the previous agreement, Trigon has added language to this section to protect physicians. Trigon has committed to including statements that notify recipients of potential data limitation that could affect interpretation of the information and has provided the physician with the opportunity to review economic profiling information 30 days in advance of any external publication. As stated in Section III.K., you may provide comments and questions to us for our consideration by telephoning our Health Economics Unit at 1-800-447-2345.
5. Trigon's determination that certain health care services are not Medically Necessary represents a denial of payment, not a denial of treatment. Only if Trigon deems the provision of certain health care service to be not Medically Necessary and thus a non-Covered Service, the physician is responsible for making the decision to provide or not to provide treatment based upon his/her professional judgement. If based upon his/her professional judgement, the physician wishes to provide the non-Covered Service to the Covered Person, or if the Covered Person is adamant about receiving such services, the physician can bill the Covered Person directly provided that an appropriate Patient Waiver form has been completed. Trigon does not assume liability for payment of non-Covered Services on behalf of Covered Persons. This practice, along with the definition of Medical Necessity and Covered Services are supported by the Covered Person's Evidence of Coverage.
6. See number 1.
7. Further clarification necessary.
8. Under the Trigon Services. Inc. agreement, all Affiliates are obligated to pay clean claims for Covered Services in accordance with the timeframe imposed by the Fair Business Practices Act.
9. All Affiliates listed on Exhibit A of the Agreement are, per Section I.A the definition of Affiliate, party to the Agreement and are subject to the terms and conditions expressed in the Agreement. Also, the definition of Plan refers to Blue Cross Blue Shield plans participating in the BlueCard Program. Likewise, these Plans are subject to the terms and conditions expressed in the Agreement including Exhibit H. Section III.P states that the Provider will comply with the utilization review policies of such Plan in lieu of the utilization review policies in Exhibit F. A list of Plans participating in the BlueCard Program will be mailed to you upon request.
10. Further clarification necessary.
11. In this instance, please call your Provider Network Consultant and he/she will serve as the liaison to the Trigon corporate office to resolve the issue.
12. The Trigon Reference Guide will be mailed to providers in late January 2000. This Reference Guide will have updated information and include provisions from the Ethics and Fairness in Carrier Business Practices Act.
13. Trigon does not publish or disseminate distinct medical record consent forms.
14. All self-insured plans administered by Affiliates are required to comply with the obligations in Section II, Trigon Services, Inc. and Affiliate Obligations, which include Ethics and Fairness in

Carrier Business Practices Act provisions. Self-insured plans are also subject to Section III.M and thus, in certain situations, may be liable for payment.

15. If a non-participating provider has provided services to a Covered Person, Trigon will pay the claim directly to the Covered Person. The reimbursement varies according to the benefit structure of the Covered Person.

I hope that this information addresses some of your concerns regarding contract language. If you require further explanation or wish to discuss these issues in greater depth, please notify me upon review of this letter. I am also researching your concerns that were not addressed in this letter and will notify you once completed. If you have any questions, please contact me at 703-227-5316.

Sincerely,

Keane Chan
Provider Network Consultant – Northern Region

cc: Sara D. Bajkowski, Network Contracting Representative, Fairfax-Prince William Hem/Onc
Gary Miller, Director, Provider Networks – Northern Region

Exhibit 56

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

CIVIL ACTION: 01-CV-12257 PBS

----------X

IN RE: PHARMACEUTICAL INDUSTRY :

AVERAGE WHOLESALE PRICE LITIGATION :

----------X

HIGHLY CONFIDENTIAL PURSUANT TO PROTECTIVE ORDER

Wednesday, September 22, 2004

10:33 a.m. - 4:43 p.m.

Deposition of MARGARET M. JOHNSON, R.Ph., taken by Defendants, pursuant to Subpoena, at the offices of Horizon Blue Cross Blue Shield, Three Penn Plaza - East, Newark, New Jersey, before Ellen Marie Gumpel, a Certified Shorthand Reporter, Registered Professional Reporter and Notary Public within and for the State of New York.

become aware of that fact after coming to Univera or did you become aware of it previously?
A. That doctors in general made a margin. I know that I assumed that physicians were making a margin buying and being reimbursed for drugs, yes.
Q. Can you identify any particular time frame when you first would have become aware of that fact?
A. Probably most associated with my work in the director of pharmacy role for Blue Cross and Blue Shield where I was involved in more work related to physicians than my very specific role under the PBM.
Q. Forgive me for getting confused about dates, but could you remind me of when that was that you were director of pharmacy?
A. 1993, '94.
Q. Would it be fair to say that -- I'm sorry.
A. No, it started in '94 through '99.
Q. Would it be fair to say as director

of pharmacy services your principal sphere of responsible pertained to pharmacies, rather than providers?
A. Absolutely, yes.
Q. Despite that, although you weren't involved with providers, you were aware of the fact that providers were making a margin?
A. Yes.
Q. Would it be fair to say that the existence of that margin for providers is something that is well known in the industry?
A. Yes.
Q. It was certainly well known by 1993 and '94, correct?
A. I believe it was known in '93 and '94.
Q. It is certainly well known today, correct?
A. Yes.
Q. At the time that you were working for Univera, did you Univera contract with any PBMs?

A. Yes.
Q. Which PBMs did Univera contract with?
A. Centrus.
Q. Would you mind spelling that for the court reporter?
A. C-e-n-t-r-u-s.
Q. What tasks or responsibilities did Univera delegate to Centrus?
A. We delegated claims processing. They provided clinical support for our pharmacy and therapeutics committee. They did rebate administration for us and I think supported competitive analysis and benefit design analysis and analytics and reporting those types of things.
Q. In terms of rebate administration, you're referring to rebates that were paid to Centrus by drug manufacturers; is that correct?
A. Yes.
Q. Did Centrus pass on all, 100 percent of those rebates to Univera?

A. Univera held the contracts and received the rebates sometimes directly, sometimes through Centrus and there was a percentage share of the rebates, I believe at that time was the financial arrangement between Univera.
Q. Do you recall what the percentage share was?
A. I believe I recall. I am wondering if it's information that is not to be shared.
MS. LEONARD: Beyond the scope of your deposition.
THE WITNESS: I mean, I'm not employed there now and I'm concerned about the proprietary nature of that information.
MR. MANGI: Actually, that reminds me, I should put on the record, since we will be going through some documents from Horizon that have been marked as Highly Confidential Pursuant to Protective Order that has been entered by the judge in this case, I would like to designate this transcript of this deposition as highly

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appear to be the version of the old chart that was in effect from August of '01 through and until June of '04; would that be correct?
A. I have no idea.
Q. Now, you mentioned that your current title at Horizon is executive pharmacy director.
A. Right.
Q. What are your responsibilities in that position?
A. My responsibilities are management of the pharmacy benefits for Horizon Blue Cross and Blue Shield of New Jersey, as well as Horizon Healthcare New York. And that includes oversight of our PBM arrangement, clinical management of our P&T and related clinical programs or unrelated clinical programs. The administration includes benefit design, all of the interfaces with the PBM. We have a business development area and specialty pharmacy and audit and utilization management. And then sales support, those things that I think I mentioned previously.
Q. Do you subscribe to any periodicals

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on prescription drug pricing, on that topic generally?
A. We have many periodicals and I'm sure some of them relate to the prices of prescription drugs.
Q. Do you personally subscribe to any of these periodicals?
A. They may be addressed to me. They're not my personal subscriptions. They're corporate subscriptions.
Q. Do you know if they include price reporting services?
A. We may receive something from Red Book or First Data Bank. We don't directly subscribe to that.
Q. You're familiar with those price reporting compendiums, Red Book and First Data Bank; is that right?
A. Yes.
Q. And you're also familiar with Medi-Span?
A. Yes.

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Q. What is your understanding of the prices that are listed in those price compendiums?
Do you know what is listed in them?
A. Do I know what is listed?
Do you mean, how they're referenced?
Q. Right.
A. They're listed generally alphabetically by drug with one or more prices.
Q. Do you know whether or not the prices are referred to by any particular term?
A. I believe that generally there is a published AWP and I think sometimes, not always the wholesale acquisition cost. I believe that. I'm not absolutely certain.
Q. You're aware that there is a differential between the two?
A. I am aware of that.
Q. What is your understanding of the relationship between the WAC and the AWP?
A. My understanding is that there is a percentage differential. I don't know if you

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would call it a markup, but a percentage differential between the wholesale acquisition cost and AWP.
Q. And do you know what that markup is in general for drugs?
A. My understanding is that it varies.
Q. To calculate what the differential is for a particular drug, you could go to the price reporting service and take a calculator and calculate the percentage differential between the two, assuming both were published?
A. Yes.
Q. Are you a member of any industry associations at present?
A. I am.
Q. Which industry associations are those?
A. The Academy of Managed Care Pharmacy, AMCP.
Q. How long have you been a member of AMCP?
A. Let's see. I've probably been a

Exhibit 57

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE PHARMACEUTICAL	)	
INDUSTRY AVERAGE WHOLESALE	)	MDL No. 1456
PRICE LITIGATION	)	Civil Action: 01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
ALL CLASS ACTIONS	)	

Deposition of CAROL SIDWELL, taken before GREG S. WEILAND, CSR, RMR, CRR, Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Court pertaining to the taking of depositions, at Suite 300, 1630 Fifth Avenue, in the City of Moline, Illinois, commencing at 10:38 o'clock a.m., on the 17th day of September, 2004.

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MS. KNOLL: Erik, Carol has not been sworn in.

MR. HAAS: Can you swear in Carol.

(Witness sworn.)

CAROL SIDWELL

after being first duly sworn, testified as follows:

EXAMINATION

BY MR. HAAS:

Q. Ms. Sidwell, would you please state your full name for the record.

A. Carol Sidwell.

Q. And what is your current position?

A. Manager of provider relations.

Q. And as manager of provider relations, you report to Michael Beaderstadt, correct?

A. Beaderstadt, yes.

Q. Beaderstadt. I'm going to walk through with you the same background that we walked through with Michael, and I apologize for putting you through it.

But if you would, could you starting with post high school just quickly describe for me your

Page 7

employment and educational experience.

A. Okay. After graduating from high school, I went to the University of Iowa, graduated from there in 1981 with a degree in pharmacy. During that time there were miscellaneous jobs including restaurant and lifeguarding and non-drug-related experiences.

Q. Me too, both of those.

A. After graduating in '81, I worked for a retail pharmacy chain for about nine months or so as a staff pharmacist filling prescriptions, billing insurance claims.

MS. MacMENAMIN: I'm sorry, the phone seems to be cutting out a little bit. I don't know if the speaker is too far away from the witness.

MR. HAAS: I'll turn up the volume too and see if that helps out at all.

BY MR. HAAS:

Q. Okay. The witness testified that she worked for a retail pharmacy chain as a staff pharmacist and filling prescriptions.

Is that correct?

Page 8

A. Correct. From there I started working at a hospital pharmacy reviewing the physician orders, overseeing injections, filling of the medication carts, being a resource to the physician within the hospital pharmacy environment.

Q. What is the time frame that you worked in the hospital?

A. I would have to check for exact dates on that, but I believe I started there in '82 or '83, and I worked there for about a three-year time frame, and I left there to then go back in retail pharmacy working for a different chain as a pharmacy manager in one of their retail locations. I worked with that organization in various functions managing pharmacies until 1993, when I became to John Deere Health.

Q. And how have your responsibilities and titles changed from 1993 to date while at John Deere Health?

A. When I first came to John Deere Health, I don't remember the exact title. I believe it was a pharmaceutical care representative where I would go

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out and work with physicians, talk with them about their prescribing habits, their formulary utilization, generic utilization, trying to use first line agents.

I was then involved in some special projects putting together a preferred drug list for our TennCare product, the Tennessee Medicaid product, and then went on to other special projects working with what we refer to as the health center or our clinic, our staff model HMOs. As we were building new facilities, I was responsible for designing the pharmacy, hiring the pharmacy staff, getting the licensure, setting up the purchasing agreements for those clinics.

And then I went to the provider contracting area where I became responsible for pharmacy contracting and pharmaceutical manufacturer contracting for rebates, as well as the customer service provider service aspects of pharmacy, the claims processing, authorizations, implementation of the drug benefit, interactions with the claims processor.

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of the items available, all of the drugs available within that given entity and what a -- I'll call it an average or what an average price would be looking at brands and generics available.

Q. Is it your understanding that the MAC price that John Deere develops as a proprietary price will differ from the MAC price that other health plans use?

A. Certainly.

Q. And is it fair to say that AWP is not the basis for the MAC price that John Deere has developed?

A. Absolutely. It is used as one of our benchmarks in looking at determining a MAC price, where we would like to achieve at least a certain percentage discount, but it certainly is not the biggest factor.

Q. During the course of your tenure at John Deere, has John Deere done any studies or costs of provider or pharmacy costs of acquisition of drugs to your knowledge?

A. I wouldn't say we have done any formal

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studies of that. Certainly information is available through journals and through other means to allow us to know that our reimbursement for pharmacies and for physicians does include a margin in there.

On occasion, if a pharmacist would request that we change a MAC price or change a reimbursement for a drug, they do have the opportunity to submit their acquisition cost in there.

Q. Okay. When you referred to the sources of information about drug costs, is there anything that particularly comes to mind that you've reviewed over the last decade?

A. Some of it comes from the various manufacturers. Some of it is a claim review from a pharmacy where they didn't feel that the reimbursement was enough and were willing to provide information. Some of it is drug topics or some of your journals, conferences such as the Academy of Managed Care Pharmacy, some of the networking opportunities there.

On occasion some pharmacies have or physicians have provided a copy of an invoice to us

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to demonstrate what their cost was.

Q. To sort of reiterate the conclusion you just made, it's fair to say that in providing reimbursement to pharmacies and doctors, John Deere understood that it was providing an element of margin to the physicians and the pharmacies; is that correct?

A. That is correct, yes.

Q. Now, you also mentioned that you were involved in the development of John Deere's staff model HMO.

A. Of the pharmacy pieces of that, yes.

Q. Okay. And did that staff model HMO have a particular name?

A. John Deere Family Health Plan.

Q. Family. And is it correct that that HMO was in operation from 1993 to 1999, to the best of your recollection?

A. Those dates sound close. I'm not sure when it actually ceased operation.

Q. Describe for me once again what exactly your involvement was with the HMO.

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A. I was involved with -- we had one HMO, one staff model that was up and running at that point, another one that was under development, and we were looking at opening some additional sites.

So I was responsible for getting the licensure for the facility, working with the architects and other people as far as the layout of the pharmacy, the actual design of the pharmacy, hiring a staff, setting up arrangements with the wholesalers and with the various buying groups, some involvement with the manufacturer contracts for own use purchasing at that point, and pharmacy systems, basically getting the pharmacy up and ready to run.

Q. Were you involved at all in the negotiation or contracting for drugs that were going to be dispensed by the staff model pharmacies or administered by the staff model physicians?

A. Some of the agreements were already in place when I came on board because we had pharmacies in operation, but we did extend those to other facilities.

Q. Were those contracts with wholesalers or

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BY MS. MacMENAMIN:
Q. Okay. You also testified as to your belief that the pharmacies had a reasonable margin built into the reimbursement that they received from you?
MR. HAAS: Objection to form.
THE WITNESS: Yes.
BY MS. MacMENAMIN:
Q. Can you give us a ballpark guess as to what that reasonable margin might have been?
MR. HAAS: Objection to form.
THE WITNESS: I don't know that I know their specific margin. I do know that even at AWP minus 20 that they were still able to cover their operating expenses without losing money, so whatever their operating costs would be, their margin was still there to cover that along with the dispensing fee component that we pay.
BY MS. MacMENAMIN:
Q. Okay.
A. If you look at a pharmacy, in the data that I've seen, it looks like the average cost to

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dispense a prescription used to be 6 something. I think it's 7 or 8 something per prescription now. And if I'm paying them as in some of these contracts $1.75 or $1.49 per prescription, there has to be additional margin in the drug cost for them to be able to continue to be in business.
Q. Okay. From what you're saying, I understand that you find AWP to be a useful benchmark in place of actual acquisition cost?
MR. HAAS: Objection to form.
THE WITNESS: Yes. It's an industry standard.
BY MS. MacMENAMIN:
Q. And would you say that it's a useful benchmark because it has a relation to some kind of real world price?
MR. HAAS: Objection to form.
THE WITNESS: I would say that it's useful because it is a benchmark, because it is an industry norm that then I can apply discounts to to get consistent adjudication of claims.
BY MS. MacMENAMIN:

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Q. Are you aware of any other benchmarks that are available for use in reimbursing pharmacies?
A. Certainly like the HCFA MAC would be a benchmark price. That's one that I don't -- we don't use in our business to implement it. We use it as one of the things in compiling our own MAC pricing.
Q. Is the HCFA MAC exclusive to generic products?
A. I believe so. It doesn't include all generics.
Q. So just speaking of brand name drugs here exclusively, are you aware of any other benchmarks available for use in reimbursing pharmacies?
I'm sorry, I didn't hear your answer if you did answer.
A. I'm still thinking. I'm not aware of any easily definable other benchmark out there. Certainly there are different sources of AWP than what we use today.
Q. So if you learned that AWP did not have a relation to any sort of real world prices, would

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that affect your negotiations with pharmacies in using AWP as a benchmark?
MR. HAAS: Objection to form.
THE WITNESS: I guess I already understand that AWP is not necessarily a direct linear relationship to the cost or the price that that pharmacy pays for the drug, so since I know that today, I'm not sure that it would change the way I'm doing business or the way I'm contracting with my pharmacies.
BY MS. MacMENAMIN:
Q. In your negotiations with manufacturers for rebates and discounts, are those negotiations also based on the benchmarks AWP and WAC?
A. Those are certainly two of the things that are used to calculate the various levels of rebates.
Q. Can you tell me of any other benchmarks that are available?
A. I look at the other costs of drugs in that class based on AWP, based on WAC, and based on the rebate amounts that the other manufacturers are willing to offer to get down to a net price.

Exhibit 58

IN THE DISTRICT OF MASSACHUSETTS

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IN RE:	:	
PHARMACEUTICAL INDUSTRY		MDL No. 1456
AVERAGE WHOLESALE PRICE	:	01-CV-1225
LITIGATION		

30(b)(6) DEPOSITION OF: IHC HEALTH PLANS

ERIC CANNON

-O-

Place:	IHC Health Plans
	4646 West Lake Park Blvd.
	Salt Lake City, Utah 84120
Date:	September 13, 2004
	9:40 a.m.
Reporter:	Vickie Larsen, CSR/RPR

-O-

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EXHIBITS

No.	Description	Page
Exhibit Cannon 012	1999maf	159
Exhibit Cannon 013	2001 HPI Physician Fee Schedules	164

-oOo-

September 13, 2004 9:40 a.m.

PROCEEDINGS

ERIC CANNON,
called as a witness, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. EVERETT:

Q. Would you please state your name and current position for the record.

A. My name is Eric Cannon. I am Director of Pharmacy Services for IHC Health Plans.

Q. Mr. Cannon, have you been deposed before?

A. No.

Q. Let me just run through some of the basics of the deposition.

First of all, as I'm sure you realize now, you are under oath. So it's just like you're in a courtroom. Do you understand that?

A. Yes.

Q. And because there is a court reporter here who's taking down everything that's said, it's important that you wait until I finish my question before answering.

A. Okay.

Q. Do you understand?

And that you speak out loud. The court reporter can't take down head nods.

A. Yes.

Q. If you don't understand anything in any of my questions, feel free to ask me to clarify. I'm happy to do that.

A. Okay.

Q. And if you need to take a break, let me know and I'm happy to do that as well, as long as there's not a question that is pending.

A. Okay.

MR. LAWLOR: Clay, then just for purposes of the protective order, we'd like to consider everything that Eric says here highly confidential.

MR. EVERETT: Okay.

Q. Mr. Cannon, you understand that you're

here today testifying on behalf of IHC Health Plans?

A. Yes.

Q. And that my questions today will go to the knowledge of the company, unless I indicate that I'm asking for your personal knowledge. Do you understand that?

A. Yes.

Q. Okay. I'm going to hand you what I'm marking as IHC Deposition Exhibit 1.

(Exhibit Cannon 001 was marked for identification.)

Q. BY MR. EVERETT: Which is the Amended Notice of Deposition of IHC Health Plan that was sent out last week. Are you familiar with this document?

A. I have seen it before.

Q. On Pages 3 through 6 of the document are a list of deposition subjects. Have you seen these deposition subjects before?

A. Yes, I have.

Q. Are you prepared today to testify about IHC Health Plans' knowledge with regard to each of these deposition items?

A. Yes, I am.

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the other services or procedures provided in a physician's office.
Q. Does IHC Health Plans have any capitation contracts with the providers?
A. Not currently that I am aware of.
Q. Did it have capitation contracts with providers in the past?
A. I'm unaware.
Q. If you will turn, please, to IHC AWP 121. At the bottom of the page and carrying over into Page 122 indicates that:
"Provider will be paid [at] the lesser of [the] Provider's current prevailing fee or the amounts on the Health Choice Maximum Allowable Fee Schedule."
Do you see that?
A. Uh-huh.
Q. Are prescription drugs included on the maximum allowable fee schedules?
A. Yes, they are.
Q. And are there different maximum allowable

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fee schedules for prescription drugs for different products sold by IHC?
A. Yes, there are.
Q. Did IHC Health Plans understand that providers were earning some margin on their sales of physician administered drugs?
A. Yes.
Q. Are there any particular groups of physicians that are must haves for the IHC Health Plans now?
A. IHC Health Plans must maintain a provider network that meets the medical needs of our patients. So we must have adequate numbers of primary care physicians that would include internal medicine, family practice, pediatricians. We must have adequate numbers of specialty providers, whether they are orthopedic surgeons, hematologists, oncologists, rheumatologists, neurologists.
Is anyone of those providers a must have over the other? I don't think, although from time to time there may be a specialty with whom we are more challenged to have access than another.

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Q. Are there separate negotiations with providers about fee schedules?
A. Yes.
Q. Do different providers -- are different providers paid based on different fee schedules by IHC Health funds?
A. For injectable drugs all providers are paid off the same fee schedule -- or physician -- it would be better if I said physician administered drugs as opposed to injectables.
Q. So there's a single fee schedule for all physician administered drugs?
A. Yes.
Q. Have any providers threatened to leave IHC Health Plans network due to the amount that's included on the fee schedule for physician administered drugs?
A. Yes.
Q. And how did IHC Health Plans respond to that threat?
A. The threats that I'm thinking of were in response to our negotiating over lowering the price we

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currently paid or changing the reimbursement methodology for injectable drugs, and it centered around rheumatologists.
Q. And did IHC Health Plans maintain its contractual relationship with those rheumatologists?
A. Yes, we did.
Q. Did IHC Health Plans change its methodology or lower its payment for physician administered drugs to those rheumatologists?
A. No, we did not.
Q. Did IHC Health Plan try to figure out providers cost in determining the amounts that they would agree to reimburse based on a fee schedule for physician administered drugs?
A. Can you repeat that.
Q. Sure. Did you try to figure out what physicians were paying for drugs that were reimbursed by IHC Health Plans?
A. I don't think we tried to figure out what they were paying. I think we had a ballpark idea of what they were paying. Did we do an analysis or go to a lot of work to figure out? No.

Exhibit 59

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
- - -

In Re: PHARMACEUTICAL	:	MDL DOCKET NO.
INDUSTRY AVERAGE WHOLESALE	:	CIVIL ACTION #
PRICE LITIGATION	:	01CV12257-PBS

THIS DOCUMENT RELATES TO:
ALL ACTIONS

The deposition of PAULA PFANKUCH, called by the Defendants Pfizer, Pharmacia, and Upjohn for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before KIMBERLY WINKLER CHRISTOPHER, a Notary Public within and for the County of Kane, State of Illinois, and a Certified Shorthand Reporter of said State, taken at 300 East Randolph Drive, Suite 2800, Chicago, Illinois, on the 14th day of September, 2004, at the hour of 9:40 o'clock a.m.

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A. The case involves Evergreen Medical and our ClaimCheck product.
Q. Okay. So you've been through this before. You know, I think, the ground rules. I'm going to ask you some questions today, and you're going to answer them. The court reporter is going to be writing down what we say, so it's important both that we talk out loud as opposed to, you know, in casual conversation you'll nod your head or smile to answer and that sort of thing that she can't really take down. So it's important, especially with yes-or-no questions, to make sure we get a verbal answer that we can put on the record.
It's also important that we take turns. So if, you know, you'll let me finish my questions before you start your answer and I'll do my best to not interrupt you and let your answers finish so that -- she can't really take down if two people are talking over each other, just so that we can be clear, make sure that we understand everything.

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My job today is to ask you clear, precise questions that you can understand and answer. I guarantee you there will be some point where I will fail in that endeavor and will ask you a question that you will not understand. And if I do that, just let me know. Just say, you know, I don't understand that question, can you clarify it or ask it another way. So just let me know if you have any questions about anything.
As I think you understand, you're here testifying today as a representative for Health Care Service Corporation which we all typically call BlueCross BlueShield of Illinois.
One of the issues that that will present is as I'm asking my questions, I will probably use the word "you" a lot, such as do you know or did you know X, Y, or Z. And when I do that, what I'm asking for is any knowledge that you know on behalf of the corporation. So if a colleague has told you something about how the company does business, if you could provide that sort of information as well in addition to

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anything that you may know personally because what we're trying to get at is everything that your company knows about these topics that we're going to be asking about today.
Do you have any questions about that?
A. No, I don't.
Q. What is your official position at BlueCross BlueShield of Illinois?
A. Senior manager, professional reimbursement programs.
Q. And what exactly does that position entail?
A. It's a fairly wide scope. It involves three slightly different but related areas. Probably the most prominent is the reimbursement to professional providers. That includes physicians.
Additionally, I'm responsible for the ClaimCheck auditing within our adjudication system. Additionally, we maintain the procedure code master file that allows professional claims to be processed.

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Q. And when you say the procedure code master file that allows claims to be processed, that's some sort of automated system?
A. It's an automated system. I'll give you an example to help clarify.
If you look at the AMA CPT manual, you'll see approximately 6,000 procedure codes. Those procedure codes, along with their descriptions, have to be placed on the adjudicator to allow claims to come in and be processed through the system. So we are responsible for getting that procedure code out there and assimilated information.
Q. Okay. Do those codes include J codes for physician-administered drugs?
A. It includes the CPT codes as well as the HCPCS codes H-C-P-C-S -- I believe. And that's where the J codes would fall.
Q. We deal so much with drugs sometimes we forget there are other codes out there other than the J codes.
How long have you held your position as

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Q. When we left off, we were talking about the use of AWP as a benchmark.
Did BlueCross BlueShield of Illinois understand that using a benchmark may result in some providers getting a higher margin on drugs?
A. What BlueCross BlueShield realizes is that certain physician groups may because of their volume be able to purchase things at a lower rate than others.
Q. And if all purchase groups are being reimbursed at the same rate, then they would have different margins for their drugs; is that accurate?
A. That would be accurate.
Q. Did BlueCross BlueShield of Illinois accept those different margins as a cost of being able to use a benchmark?
A. I guess I don't understand what you mean by "cost."
Q. Were you willing to allow different providers to earn different margins so that you could use a benchmark for pricing?

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A. BlueCross's decision had less to do with that type of thinking than it did with our pricing system. Accept one price for one procedure code per fee schedule. So regardless we can set one price for everybody.
Q. So it was in essence a technical decision you had to agree on one price?
A. Yes, that would be correct.
Q. You mentioned for several of the fee-for-service plans such as the PPO that there's a defined physician network.
How are those networks created?
A. Those networks are created by provider affairs. Provider affairs contracts with the various specialty providers. It extends beyond physicians certainly to other provider types, so I don't want you to think it's strictly physicians. Some of that is dictated by the direction of the medical marketplace, where things are going. And some of that is dictated by our large national accounts, but all of the contracting is done by provider affairs.

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Q. Do you know how that negotiation worked for reimbursement of the providers?
A. The PPO does not have a negotiation process. The PPO is a set fee schedule, or SMA as we talked about earlier. And it is a take-it-or-leave-it proposition from a pricing perspective.
Q. So all providers are reimbursed at the same rate?
A. Until the last two to three years, that is correct.
Q. And what happened in the last two or three years to change that?
A. In the last two to three years, we've had a few very large, prominent provider groups pressure us into paying slightly higher rates because they are key to the network. We had no choice but to develop separate fee schedules for those providers.
Q. So an increase in the amount of reimbursement is one of the tools that you use to keep these large, prominent provider groups in

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your network?
A. In limited circumstances, very limited circumstances.
Q. But that has happened?
A. Yes, it has.
Q. Do providers compete to be in your network?
A. I don't know what you mean by "compete."
Q. Let me put it another way.
Does any provider who wants to be in the BlueCross BlueShield network -- are they able to join the network assuming that they're willing to agree to the fee schedule?
A. In terms of the PPO, that is correct, assuming they are what we consider a solicited provider type, meaning physicians are solicited and therefore any physician that's willing to accept our fee schedule and the other terms that you've seen in the contract -- if they elect to agree to that, they can be in the network. If not, they wouldn't be in the network.

Exhibit 60

HIGHLY CONFIDENTIAL - ATTORNEYS' EYES ONLY

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

In Re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL No. 1456 CIVIL ACTION NO. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO ALL ACTIONS	)	

30(b)(6) DEPOSITION OF DAN DRAGALIN, M.D.
New York, New York
Friday, September 17, 2004

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A. Generally it occurred when I was the corporate medical director of Prudential in the '80s, and there were a number of insurance issues, suits, et cetera.
Q. Okay.
MS. FELLER: Excuse me. Who is on the phone?
MR. MACORETTA: I'm sorry, this is John Macoretta from Spector, Roseman & Kodroff for the plaintiffs. Good morning.
MS. FELLER: Good morning. This is Marcy Feller. John, can you spell your last name?
MR. MACORETTA: Sure. Macoretta. M-a-c-o-r-e-t-t-a.
MS. FELLER: Thank you.
MR. MACORETTA: Dr. Dragalin, can you just move the phone a little closer or speak up?
THE WITNESS: All right. There you go.
MR. MACORETTA: That's much better. Thank you.

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MR. WELLS:
Q. Okay, we were talking about your prior depositions. Obviously I think you know the rules and how this works. I'm going to ask you questions, you're going to answer them, the reporter is going to write everything down. For that reason it's really important that we take turns and not talk over each other so that we can get a clear transcript. It's also important that we give verbal answers as opposed to nodding the head and that sort of thing as you might do in casual conversation so that the reporter can get everything down.
My task today is to try to ask you clear questions that you can answer. I assure you at some point I will not do that, there will be a question that you don't understand. If and when I do that, just let me know and I'll try to rephrase it or ask it another way.
If you need a break for any reason, just let me know. And I don't think John was on the phone, but I think we're going to take an

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early lunch around 11:30 so that Dr. Dragalin can step out for a quick conference call, and then reconvene somewhere shortly after noon.
MR. MACORETTA: That's fine.
Q. Also you're here testifying, as you know, as a representative of MultiPlan, and throughout the deposition I'll probably use the term "you" in some of my questions, and when I use that I'm going to be referring to MultiPlan as a company, not necessarily you as an individual. So if there's information that you have that might be from documents or other people in the company, if you could provide that as well, that would be appreciated.
Do you understand that?
A. Yes.
Q. Okay. Dr. Dragalin, what is your educational background?
A. I went to undergraduate school at the Georgia Institute of Technology, got a BS in applied biology.
I went to medical school at

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Georgetown University, got an M.D. there. I did my residency, pediatric internship and residency at Emory University in Atlanta.
Board certified in pediatrics. And then at Emory I received a master's in public health. And there's a couple of fellowships thrown in there somewhere.
Q. And what is your position at MultiPlan?
A. Executive vice president in charge of the network.
Q. And how long have you held that position?
A. About a year and three months.
Q. And what did you do before that?
A. I was the president of the Northeast region for Great West Life Insurance.
Q. And what generally were your responsibilities at Great Western Life? Great West Life?
A. I had a 13-state region covering the whole northeast, down through Virginia, and I had

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would be excessive, and we would use the AWP knowledge to substantiate our claim, our charge.
Q. And what were the providers' typical reactions to that?
A. Too bad for you.
Q. And this e-mail continues later, and I quote: "It is also not difficult to convince providers (principally oncologists, nephrologists and endocrinologists, dialysis centers and home infusion agencies) to accept, as payment in full, some variation of average wholesale price (AWP) (or- 10%) since they know they have been ripping off the payor community for decades."
Is that an accurate statement?
A. Yes.
Q. Why do you believe that the doctors knew that they were "ripping off the payor community for decades"?
A. Well, because they know what they get the price for. I mean they know what they buy the drug for and they know what they're charging the drug out for. And in general their attitude

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is, especially -- I mean the oncologists are the most egregious -- their attitude is that by substantially overcharging for the drug, they're making up for the underpayment they receive for the rest of their services. So to them it's a balance that they evoke.
Q. Did you ever have any discussions with your payor clients about that?
A. With selected ones, yes.
Q. Did you ever specifically discuss the idea that some providers felt that the reimbursement levels were appropriate to compensate them for undercompensation for their services?
A. Yes.
Q. And what were the payors' reactions to that?
A. Well, they varied, but there were proposals such as, well, you know, why don't we increase the administrative portion of the bill so that we can, you know, so that a decrease in the AWP -- or a decrease in the reimbursement for

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the actual drug, it would be more palatable.
Q. And did any payors, to your knowledge, actually go in that direction?
A. Not through us. They might have through their own primary networks, but not through us.
Q. Did any payors say something along the lines of yes, we understand that we're providing a margin on a drug to compensate these providers for their services?
A. Yeah, they all agreed to that. It's the size of the margin that's the issue here. Well, the size and the variability of the margin, I should say.
Q. Is it fair to say that different payors had different expectations of what those margins should be?
A. Yes.
Q. I would like to move on to a second e-mail here, this one is on page 12, and it's the second e-mail, actually, on the page from you to a group of people beginning with Andrea Rowe, and

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dated June 16 of 2003. Do you see that?
A. Yes.
Q. And it, No. 2 in this e-mail makes a proposal to, quote, "reprice all J and Q codes at AWP and determine additional potential savings."
Why did you recommend to reprice at AWP?
A. Well, the recommendation was not to reprice at AWP, rather, it was to run an analysis repricing at AWP, and by finding out the difference between AWP generically and what we were repricing at, we would then have the margin, if you will, and then we could analyze applying various factors to the margin -- you know, plus 10 percent, plus 20 percent, et cetera. So it was an analytic exercise, not a recommendation that we reprice at AWP.
Q. And if we could look at the third e-mail, which is on page 24 of Exhibit 2. It's an e-mail to you from Karen M-u-c-c-i-n-o dated June 16 of 2003.
A. Right.

Exhibit 61

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

IN RE:	)	
	)	
PHARMACEUTICAL INDUSTRY	)	Civil Action No.
AVERAGE WHOLESALE PRICE	)	01CV12257-PBS
LITIGATION	)	

HIGHLY CONFIDENTIAL
DEPOSITION
of JOE SPAHN

Taken at Anthem
4361 Irwin Simpson Road
Mason, Ohio 45040
on November 30, 2004, at 9:12 a.m.
Reported by: Rhonda Lawrence, RPR/CRR

-=0=-

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JOE SPAHN
being first duly sworn, as hereinafter certified, deposes and says as follows:
EXAMINATION
BY MR. MANGI:
Q. Good morning, Mr. Spahn.
A. Good morning.
Q. As I said, my name is Adeel Mangi. I'm from the law firm of Patterson, Belknap, Webb & Tyler. We represent the defendant drug manufacturers in this case.
MR. MANGI: Before we begin, pursuant to a conversation I just had with counsel for Anthem, we're going to designate this deposition transcript and the transcripts for all Anthem witnesses we'll be taking over the next couple of days as highly confidential pursuant to the protective order. And we can revisit that as to sections as necessary in the future.
MR. THOMAS: Great.
Q. Mr. Spahn, thank you for taking the

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time to speak with us today. Have you ever been deposed before?
A. I don't believe so. I don't ever recall having, like, a court reporter. So I think the answer's no.
Q. Okay. Let me just run through some of the standard ground rules for a deposition, then.
The first is, it's important that you answer all questions verbally so that the court reporter can take down your answers. She can't take down a nod of the head or shrug of the shoulders. Okay?
A. (Indicates affirmatively.)
Q. And you'll have to answer that verbally.
MR. THOMAS: Say okay.
A. Oh. Okay.
Q. Just so she can write it down.
If at any point a question that I ask you is unclear, please stop me and tell me that, and I'll do my best to rephrase it.

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A. All right.
Q. If at any point during the deposition you'd like to take a break, please let me know, and as soon as possible, we'll take a break.
A. All right.
Q. What is your current job title, Mr. Spahn?
A. My current job title is senior health care consultant.
Q. And who's your employer?
A. Anthem Blue Cross/Blue Shield.
Q. Is your work focused on a particular region?
A. Anthem Midwest.
Q. What states fall within that area of responsibility?
A. Ohio, Kentucky and Indiana.
Q. How long have you been in this position?
A. Since 1992.
Q. And you've held the same title,

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senior health care consultant, since 1992?
A. Yes.
Q. Is that when you joined Anthem?
A. No.
Q. When did you join Anthem?
A. I joined Anthem in April of '87.
Q. We'll go through your employment history from '87 to the present in the moment.
But first, perhaps you could describe for me your educational background after high school.
A. I have a bachelor's in accounting and an MBA in finance.
Q. When did you get your bachelor's in accounting?
A. I got my bachelor's in 1972.
Q. Where did you get that qualification?
A. University of Cincinnati.
Q. And the MBA?
A. From Xavier University, in 1982.

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baseline.
Q. Okay. And since that's the baseline, is it fair to say that, as a general proposition, providers are seeking reimbursement at an amount greater than the Medicare fee schedule?
A. In general, yes. But there's another component, too, which is volume. You have to -- you know, if Anthem is -- drives a lot of volume to that provider, you know, they may be willing to -- because, you know, what they're looking at is their total reimbursement. You got the -- how much you're paying them for each procedure, but also the number of procedures that they do.
So if Anthem has a large membership in an area, they may be willing to take less than the actual fees, but they make more money because of the volume.
Q. So the determination of the reimbursement rate that will be paid to a practice is very much an individualized

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issue focusing on that particular practice, correct?
A. Did you say an individual practice?
Q. Let me clarify the question.
We've discussed how there are some competitive factors that give one practice a stronger bargaining practice than another, right?
A. Correct.
Q. And what we just discussed is that volume would also be a factor in determining the reimbursement rates, how much volume Anthem drives towards a particular physician practice?
A. Correct.
Q. So it's fair to say that the determination of the amount that Anthem will reimburse a practice for drugs that are administered in office turns on factors specific to that practice, right?
A. Correct.
Q. Including its competitive bargaining

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power, the amount of volume that's driven to it by Anthem?
A. Correct.
Q. Are there other factors that go into that calculation?
A. I think those are the main ones.
Q. Okay. Now, do you have an understanding -- well, withdraw that.
You know that there are some drugs that can be administered either in a physician's office or in a hospital, correct?
A. I assume there are. Again, I'm only familiar with the physician side.
Q. Okay. Do you have an understanding as to whether Anthem regards the administration of drugs in physicians' offices as being more or less cost-effective than the administration of the same drug in a hospital setting?
A. I don't know. I've never heard anyone talk about that.

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Q. Okay. Are you aware of any analysis at Anthem regarding the relative costs of administration of a drug in a physician's office versus a hospital setting?
A. No, I haven't.
Q. Now, you testified earlier that Anthem has -- does not know exactly what providers are paying to acquire drugs, correct?
A. Correct.
Q. That's not something that -- withdraw that.
Anthem does not require providers to disclose their acquisition costs for drugs as part of their contracts with those providers, correct?
A. Correct.
Q. So providers' acquisition costs for drugs do not form part of Anthem's determination of what it will reimburse them in relation to drugs?
A. Correct.

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Q. The reimbursement is driven entirely by the fee schedule?
A. Correct.
Q. Regardless of what the specific provider's acquisition costs for those drugs may be?
A. Correct.
Q. So if, for example, Anthem were to learn that a particular provider were getting a discount or a rebate on a particular drug that lowered his acquisition costs for that drug, that wouldn't change the amount that Anthem is reimbursing that practice in relation to that drug, right?
A. No.
Q. Because the reimbursement amount is tied to the fee schedule?
A. Right.
Q. And if Anthem were to learn that providers in a region were getting a discount or rebate from a drug manufacturer in relation to a particular drug, again,

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that wouldn't change the amount Anthem reimburses because that's tied to the fee schedule?
MR. THOMAS: Asked and answered.
A. Yes. That's correct.
Q. Do you know whether Anthem's contracts with providers contain confidentiality clauses?
A. I don't know.
Q. Do you know whether or not -- are you aware of any free sample programs whereby providers can get free samples of drugs from manufacturers?
A. No, I'm not aware.
Q. That's not an area that you deal with?
A. No.
Q. Are you familiar with the major drug wholesalers operating the market today?
A. No.
Q. Do you have an understanding of what wholesalers pay to acquire drugs?

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A. No, I don't.
Q. Are you familiar with prompt pay discounts?
A. No, I'm not.
Q. You've never heard that term?
A. No, I haven't.
Q. To the best of your knowledge, do you know of any instances where providers have conspired with drug manufacturers to inflate the average wholesale prices for drugs?
A. No.
Q. Are you aware of any instances where pharmacies or pharmacy benefits managers have conspired with any drug manufacturers to inflate any drug's average wholesale prices?
A. No.
MR. MATT: Objection. No foundation.
MR. THOMAS: I was just going to let it go.

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Q. Do you know whether Anthem has been involved in any litigations pertaining to average wholesale prices for drugs other than this one here today?
A. No.
MR. THOMAS: Objection. Foundation.
Q. Do you know of any other litigations that Anthem has been involved in relating to reimbursements to providers for drugs administered in office?
A. No.
MR. THOMAS: Same objection.
MR. MANGI: Let's take another quick break and then we'll look at some documents.
(Recess taken.)
BY MR. MANGI:
Q. Prior to the break, we were talking about providers' acquisition costs and the fact they're not relevant to Anthem's reimbursement amounts. Do you recall that testimony?
A. Yes.

Exhibit 62

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
NO. 01CV12257-PBS

In re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION

THIS DOCUMENT RELATES TO: ALL ACTIONS

DEPOSITION OF ROBERT C. FARIAS, called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Harvard Pilgrim Health Care, 93 Worcester Road, Wellesley, Massachusetts, on Wednesday, 20 October, 2004, commencing at 10:05 a.m.

to?
A. Next title was senior project manager; and I did that for about two years. That function was in the network management area -- a variety of projects related to network management that could be related to medical management, could be related to referral authorization type things; could be related to managing recontracting efforts. Just a wide variety of projects.
Q. When you say, "network," you're referring to networks of providers?
A. That's right. It was an internally-focused position.
Q. What do you mean by that?
A. Meaning that I didn't have contact with providers. I worked on projects that supported the work of network management.
Q. Okay. You held that position for about two years you said?
A. That's right.
Q. Okay. What was the next area that you moved into?

A. Next area was specifically to the contracting department in a project management role. That title was manager of planning and administration.
Q. Okay. And you moved into that position sometime around 2000, is that correct?
A. Probably about 2000, yeah.
Q. What were your responsibilities in that position?
A. In that position I was responsible for both the administrative side of managing the contracting department and the administrative side -- I mean the departmental administrative budget, the infrastructure of the department -- project management specific to the contracting department. For example, you know, when recontracting was, you know, kicking off, I would be responsible for drafting, you know, notification letters that would go out to the -- to the providers, responsible for working with legal on updating the contract templates, and also, managing the work flows related to recontracting. And again, a wide

variety of projects. You know, liaisons with other departments and so forth.
Q. The focus you said was entirely on the administrative side of managing the department?
A. Administration and planning. The planning -- it was really a split function, and it continues to be. But the planning side was related to, you know, the significant, you know, project business unit initiatives, contracting being primarily --
Q. How long did you remain in that position?
A. Actually, it was a little bit of an evolution. Probably about a year. That position evolved into my current role, director of planning and administration. When there was a reorganization, contracting became more of a broad business unit again. Network service and operations is the name of the business unit. So, my title now and following being manager of planning and administration for contracting was director of planning administration for network service and operations.
MR. MANGI: I'm sorry. Could you read

back that last answer, please.
(Answer read back.)
Q. So, your current position is director of planning and administration, right?
A. Right.
Q. And you've held that since 2001.
A. Yeah.
Q. Okay. Have your responsibilities changed from your manager of planning and administration position?
A. Yes. In addition to those responsibilities, I have reporting -- folks reporting to me, including the provider communications and training area. There's a small group of project managers and a budget coordinator which, again, they focus primarily on the infrastructure and administration side of things. In addition to that, the provider reimbursement area reports to me.
Q. What are your responsibilities in relation to that provider reimbursement area?
A. The manager of provider reimbursement

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who sets AWP?
A. I -- again, I didn't know that it was set. I don't know.
Q. Okay. So you have no idea who sets AWP.
A. Right.
Q. You referred to AWP as being an industry standard.
A. Yes.
Q. When you say that, do you understand that it's standard of the industry to use AWP as a reimbursement benchmark, correct?
A. Yes.
MR. NALVEN: Objection.
Q. And you understand that it's standard in the industry to reimburse at a discount off AWP, correct?
A. Yes.
Q. Mr. Nalven asked you a bunch of questions about OIG and Medicare.
A. Uh-huh.
Q. You're not an expert in OIG or Medicare, are you?

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A. No.
Q. So, you were just testifying about your general impressions, is that right?
A. Based on previous experiences, yes.
Q. Okay. But you have no precise knowledge about what the role of OIG is in relation to Medicare.
A. No.
MR. NALVEN: Objection.
Q. Now, then there were a whole bunch of questions about whether or not -- well, your knowledge of physicians' acquisition costs and so on.
A. Yes.
Q. Let's see if we can get that straight in my mind, based on your earlier testimony when we were speaking.
A. Uh-huh.
Q. Physicians' acquisition costs form no part of Harvard Pilgrim's reimbursement methodology, right?
A. Correct.

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Q. So, if a physician were committing a crime and billing for a drug that he had got as a free sample, Harvard Pilgrim would still reimburse him, but would hope that the authorities would catch up with him, right?
A. I think that's safe to say.
Q. And Harvard Pilgrim doesn't have any knowledge about what providers' acquisition costs are, right?
A. No.
Q. Doesn't require them to disclose those.
A. No.
Q. And if it learned that those were higher or lower than it currently thinks they are, that wouldn't change the fact that it reimburses that methodology, which is 95 percent of AWP?
A. Correct.
Q. Indeed, if it learned that in a particular instance physicians were getting a particular drug at a -- were getting a rebate or a discount from a manufacturer on a particular drug, that wouldn't change the fact that Harvard Pilgrim's standard

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across the board methodology is 95 percent of AWP?
A. Correct.
MR. NALVEN: Objection.
MR. MANGI: That's it.
MR. NALVEN: I have nothing further.
THE WITNESS: Okay. Great.
(Whereupon the deposition ended at 12:52 p.m.)

Exhibit 63

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

- - - -

In Re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL DOCKET NO. Civil Action # 01CV12257-PBS
THIS DOCUMENT RELATES TO ALL ACTIONS	)	

- - - -

DEPOSITION OF: RAEANN MAXWELL

VOLUME II

- - - -

September 10, 2004

Friday, 1:30 p.m.

DEPOSITION OF RAEANN MAXWELL, a witness, called by the Defendants for examination, in accordance with the Federal Rules of Civil Procedure, taken by and before Claire Gross, CRR, RDR, a Court Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at the offices of UPMC, One Chatham Center, 112 Washington Place, Pittsburgh, Pennsylvania, on Friday, September 10, 2004, commencing at 1:30 p.m.

- - - -

APPEARANCES:

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* I N D E X *

* INDEX OF EXHIBITS *

RAEANN MAXWELL,
having been duly sworn,
was examined and testified as follows:

- - - -

EXAMINATION

- - - -

BY MR. HAAS:

Q. Please state your full name for the record.
A. My name is Raeann Maxwell.
Q. Ms. Maxwell, where are you currently employed?
A. University of Pittsburgh Medical Center Health Plan.
Q. What is your current position?
A. Director of pharmacy services.
Q. Are you currently employed anywhere else?
A. No, I am not.
Q. If you would, describe your employment history after high school.
A. I went --
Q. Let me withdraw that question. First if you could describe for me your educational

history plus high school and describe for me your professional --
A. I obtained my bachelor's degree in pharmacy in 1987, went directly from my bachelor's degree into a Ph.D. program. Both of those degrees were obtained from the University of Pittsburgh School of Pharmacy. I obtained my Ph.D. in 1997 and it was in pharmaceutical sciences with a specialty in clinical pharmacy.
Q. After you received your doctorate you started as an employee of University of Pittsburgh?
A. Actually, I have been an employee of UPMC since 1988. I was a part-time pharmacist at Western Pychiatric Institute and Clinic, and that was prior to it becoming part of UPMC.

When it did become part of UPMC that is when working with the company began. I was with Western Pychiatric for sixteen years prior to coming here to the Health Plan.

In that time I was a part-time pharmacist up until 1994 in which in November

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A. No.
Q. Earlier in the deposition Mr. Haas asked you about your knowledge concerning controversy in the last decade or so concerning the use of AWP as a reimbursement mechanism, and he asked you about your knowledge concerning more recent legislation to use ASP as opposed to AWP.
He asked you whether from UPMC's perspective it mattered whether as a reimbursement basis one used an AWP minus some percentage or ASP above some percentage, and you said not to my knowledge, I believe. Is that accurate?
A. That is correct -- that is accurate.
Q. Would it make a difference to UPMC if UPMC knew that -- in the answer to the question would it make no difference to UPMC if UPMC was aware that AWP, the average wholesale price, for a particular drug was grossly inflated and was not related to the actual sales prices for that drug but it knew that

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the ASP was a true average of the actual sales price? Given that knowledge would it make a difference to UPMC as to which basis was used for reimbursement or payment?
MR. HAAS: Objection to form, characterization of the benchmarks, but you can answer if you can understand it.
Q. Were you able to follow that question?
A. Basically you're saying that -- let me paraphrase and see if I understand what you were trying to get across, that you're stating AWP is potentially inflated versus ASP which would be a truer benchmark?
Q. Basically yes.
MR. HAAS: I will object on form and foundation and characterization, among other things.
MR. VUKMER: This is Dan Vukmer. Let me talk to my client for just one second, if you wouldn't mind.
- - - -
(There was a discussion off the record.)

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- - - -
A. No, it shouldn't matter which that we would potentially use.
Q. Why is that?
A. Because regardless of which number that you utilize and you do whatever percentage minus you should still come up close to a negotiated reimbursement price to your provider which would be a pharmacy or physician.
Q. Well, the instance where -- does that assume that in the negotiation -- I don't know that the negotiation you just posited -- does that assume in that negotiation you understand that AWP is, in fact, an inflated number?
MR. HAAS: Objection, foundation, form, speculative.
A. I don't know how to answer that question.
Q. Your testimony was it didn't matter whether you used an AWP minus or an AWP plus system because you would negotiate to a particular point of reimbursement?

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A. Potentially, yes.
Q. Would you reach the same point of reimbursement if you did not understand that AWP was an inflated number?
MR. HAAS: Objection, ambiguous. What does that mean?
Q. All right. That AWP, in fact, did not reflect or, put it this way, grossly misrepresented what the actual sales prices were in the market?
MR. HAAS: Objection. She testified she didn't believe it did.
Q. You can answer the question if you understand it.
A. I don't understand.
Q. Let me ask you why wouldn't it matter -- let me see if I have time to get back to this. Under the contract with Argus, which I believe was Exhibit 6 to your deposition, at least for those pharmacies that are in the Argus network as opposed to the UPMC network, with their being reimbursed Argus is being

Exhibit 64

DATE: 7/14/92 TIME: 19:27:44 PAGE 68

JAMES BRUDNICK CO, INC.
CONTRACT BY CUSTOMER REPORT

PREPARED FOR: 059095 MEDICAL EAST-BRAINTREE (H) CUTOFF DATE: 7/01/92

CONTRACT NUMBER	CONTRACT DESCRIPTION	ITEM NUMBER	ITEM DESCRIPTION	SIZE	U/M	CONTRACT COST	NET COST	START DATE	END DATE
301901	GLAXO - MEDICAL EAST/WEST	991236	ZANTAC TAB 150MG U/D	100	EA	103.77	104.80	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	921242	ZANTAC TAB 300MG	30	EA	52.83	53.35	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	991233	ZANTAC TAB 300MG U/D	100	EA	177.60	179.37	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	991240	ZANTAC VIAL MULTI DOSE	10ML	EA	12.87	12.99	7/01/92	6/30/93
02996-10	PARKE-DAVIS - MEDICAL EAST/WEB	991751	ZARONTIN CAP 250MG	100	EA	47.60	48.07	7/01/92	6/30/93
02996-10	PARKE-DAVIS - MEDICAL EAST/WEB	991752	ZARONTIN SYRUP	16OZ	EA	46.35	46.81	7/01/92	6/30/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993006	ZEBTORETIC TAB 20/12.5MG	100	EA	67.23	67.90	3/01/92	2/28/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993008	ZEBTORETIC TAB 20/25MG	100	EA	68.06	68.74	3/01/92	2/28/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993014	ZEBTRIL TAB 10MG	100	EA	53.75	54.28	3/01/92	2/28/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993017	ZEBTRIL TAB 20MG	100	EA	57.53	58.10	3/01/92	2/28/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993020	ZEBTRIL TAB 40MG	100	EA	84.03	84.87	3/01/92	2/28/93
SVGHM00924	STUART - MEDICAL EAST/WEST	993010	ZEBTRIL TAB 5MG	100	EA	52.00	52.52	3/01/92	2/28/93
406529	DERMIK - MEDICAL EAST/WEST	993859	ZETAR EMULSION	60Z	EA	12.70	12.82	1/01/92	12/31/93
301901	GLAXO - MEDICAL EAST/WEST	994570	ZINACEF INFUSION PACK 1.5GM	10	EA	107.50	108.57	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	994572	ZINACEF INFUSION PACK 750MG	10	EA	55.36	55.91	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	994568	ZINACEF VIAL 1.5GM	25	EA	242.03	244.45	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	994566	ZINACEF VIAL 2250MG/100ML BULK	6	EA	308.15	311.23	7/01/92	6/30/93
301901	GLAXO - MEDICAL EAST/WEST	994562	ZINACEF VIAL 750MG	25	EA	131.69	133.00	7/01/92	6/30/93
DQ 92	ALCON - MEDECON	994952	ZINCFRIN EYE DROPS	15CC	EA	4.25	4.30	4/01/92	3/31/93
PVGHM00924	ICI PHARMA - MEDICAL EAST/WEST	995318	ZOLADEX IMPLANT	1	EA	254.95	257.49	3/01/92	2/28/93

MEDICAL WEST INC - CHICOPEE
INVENTORY COST AND QUANTITY WORKSHEET
SORTED BY LOCATION AND LABEL NAME
LOC: ON

NDC# / Label name	LOC	Pkg Size	UOM	Current Pkg Cost	Actual Pkg Cost	Onhand Pkg Qty	Phys. Count	Ext. Cost
00310096036 ZOLADEX 3.6MG IMPLANT SYRN	ON	1.000	EA	257.50	_____	.00	7	1,802.

Exhibit 65

BC SP

REPORT ID: IV0010MJ;IV001BZ
Date: 12/07/91

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MEDICAL WEST INC - PEABODY
INVENTORY COST AND QUANTITY WORKSHEET
SORTED BY LOCATION AND GENERIC NAME
LOCATION: F1

Generic Name/strength/form NDC#	MFG	LOC	Pkg Size		Current Pkg Cost	Actual Pkg Cost	Unhand Pkg Qty	Physical Count	Ext Cost
ALBUTEROL 00173038558	GLA	F1	20.000ML	5MG/ML SOLUTION	7.15	?	2.000	2	14.30
ALBUTEROL 00173032188	GLA	F1	17.000GM	90MCG AEROSOL	5.95	?	46.000	42	249.90
CROMOLYN SODIUM 00585067502	FIS	F1	9.000GM	800MCG AEROSOL	25.23	✓	13.000	13	327.99
CROMOLYN SODIUM 00585067501	FIS	F1	15.000GM	800MCG AEROSOL	40.14	✓	28.000	29	1,164.06

1,756.25